# ATTACHMENT A

# SCR 13 Task Force
# Preliminary Work Plan Summary

## Desired Goal

***To improve outcomes among children age 0 – 5 in Hawai`i, including reducing maltreatment, by improving the system of prevention and treatment services, with a focus on service coordination within DOH and DHS.***

## Indicators

There are three "levels" of indicators. The first level tracks the total population – these are the longest-term measures of improvement that the Task Force could hope to accomplish. The second level of indicator tracks the specific population groups that the Task Force has addressed. There is more work to be done in identifying measures for the target population groups. The third level of indicator measures improvements in the system of care.

**Population measures for young children (0 – 5) and their families**

- Reduction in number of confirmed abuse and neglect cases for children, 0-5
- Reduction in number of child abuse and neglect cases for children, 0 – 5 requiring medical treatment
- Reduction in number of re-occurrences of confirmed child abuse and neglect among children, 0-5
- Reduction in out-of-home placements for children, 0-5

**Target population measures specific to SCR 13 (more measures to be identified)**

- Increase in the number of children, 0-5, who are drug affected at birth, who are able to be maintained in their home.
- Increase in the number of substance abusing parents of children, 0-5 who are receiving treatment (inpatient or outpatient)
- Increase in Healthy Start engagement and retention rates among families that score at or above 50 on the Family Stress Checklist

**System measures specific to SCR 13**

- MOA between DOH and DHS to work together to implement SCR 13 recommendations
- Decrease in time between Healthy Start hospital assessment, Child Welfare Services intake and appropriate referral
- Coordinated assessment tools to assess risk for maltreatment used by DOH, DHS and their diversion programs.
- Increase in client (families with children, 0 - 5 served by both Healthy Start and CWS) satisfaction.
- Increase in satisfaction of workers working with families jointly between Healthy Start and CWS.

In developing its goal, the Task Force identified the following necessary system conditions that will need to be in place. These necessary system conditions reflect improvements in the system of prevention and treatment:

- Services are driven by the assessed strengths and risks, as well as the service needs of the family
- Services have the capability and capacity to meet the needs of the families they are serving
- Services adapt to the dynamic and changing nature of families
- Service coordination and data systems ensure that families can be served concurrently by, and can transition between, both DOH and DHS
- Eligibility for services is coordinated across programs
- There are common procedures that are used in state and private programs

In developing its goal and recommendations, the Task Force developed the following criteria that guided its considerations:

- Find reasonable solutions that will work – focus on the "can" and how to solve the problem
- Focus on measurable results
- Cover needs of identified target groups without increasing work load of line workers
- Improve ability to define service populations
- Identify continuum of programs and how they intersect and produce better outcomes
- Figure out how we can ensure target families receive the services they need in a timely manner
- Accept shared areas of responsibility between DOH and DHS

## Identification of Priority Populations

These are the groups of children that are most relevant to the issues addressed in SCR 13 and appear to be within the purview of the Task Force. For this report, the Task Force addressed the first four population groups below. The recommendations developed by the Task Force are generally related to system issues and problems that are relevant to these population groups.

The remaining population groups (numbers 5 – 10 below) will be addressed by the Task Force in 2004.

| Target Population Group | Estimated Size of Population Group |
|---|---|
| **1. Healthy Start assessed newborns with CWS involvement (no abuse occurred to infant)**<br>**a) CWS active families with a new born**<br>**b) Families w/ newborn reported to CWS, confirmed and opened**<br>**c) Healthy Start child identified as threatened harm – referred to CWS, but case closed shortly after 3 month Healthy Start eligibility period has lapsed** | According to Healthy Start Early Identification ("EID") data, 220 families in FY 02 and 159 families in FY 03 were receiving services from CWS at the time of Healthy Start hospital screening. On average, annually 189 families with newborns are receiving services from CWS.<br><br>According to Healthy Start EID data, on average, over the two fiscal years, 11 infants were referred to CWS for threatened harm.<br><br>These data should be verified with CWS data. . |
| **2. Family refuses Healthy Start Services or drops out of Healthy Start before services are complete** | According to Healthy Start data, in FY 03, 21% (686 families) of the families that were assessed positive by the Healthy Start Family Stress Checklist, refused Healthy Start services at intake, while 70% (2240 families) that were assessed positive, accepted services at intake. Of the families that scored 50 or higher on the Family Stress Checklist |

| Target Population Group | Estimated Size of Population Group |
|---|---|
| | (911 families), 15% (136 families), refused services at intake.<br><br>According to Healthy Start data, in FY 03, 51% of all cases (2482 families) were discharged during the year. All but 10% (511 families) of the total number of families being served were discharged after having received services for two years or less.<br><br>Healthy Start data also reveals that in FY 2003, of the cases that were discharged at three months and up to one year, 25% were families with Family Stress scores that are considered very high risk (50 or over). |
| **3. Drug affected infants** | According to CWS, on average, 17 newborns are reported to be drug exposed each month. This number is assumed to be lower than the number of newborns who are actually drug exposed.<br><br>Healthy Start assessment data shows that in FY 2003, 1298 families scored positive for substance abuse, mental health problems or incarceration. In the Healthy Start screen, 1591 families scored positive for a history of substance abuse. |
| **4. Children receiving Healthy Start services, referred to CWS:**<br><br>**a) Healthy Start active children referred to CWS: any disposition**<br><br>**b) Healthy Start child whose primary caregiver is incarcerated** | According to Healthy Start data, 22 Healthy Start families were reported to CWS during FY 2003.<br><br>These data should be cross-referenced with CWS data to identify families that Healthy Start was unable to contact or that refused services.<br><br>Healthy Start data also shows that 7 Healthy Start families had caregivers |

| Target Population Group | Estimated Size of Population Group |
|---|---|
| **c) Healthy Start child moving in to foster care**<br><br>**d) Healthy Start families in diversion services** | who were incarcerated in FY 2003. |

5. Young children over 3 months of age who missed Healthy Start screening (for example, home birth or moved to Hawai`i after birth).

6. Young children over 3 months of age in diversion services.

7. Young children whose primary care giver is incarcerated. (*This population group was considered by the Task Force and preliminary findings were forwarded to others who are working on the issues of children of incarcerated parents.)*

8. Young children, not referred to CWS – not screened into Healthy Start (the unknown risk cases).

9. Children over age 3 and under age 5, not in other programs.

10. Infants in out-of home placement (currently referred to Public Health Nursing).

## Preliminary Recommendations

The recommendations are divided into two categories below, based on the type of recommendation and how implementation will occur.

**Preliminary Program Recommendations –** these are recommendations that can be adopted by the specific programs. In some cases an agreement between the programs should be developed to ensure that there is a clear understanding of the changes to policy or procedure:

| Issue/Problem | Preliminary Program Recommendation |
|---|---|
| **Newborns with CWS Involvement**<br>A newborn whose family is a confirmed and active case with CWS generally does not get a Healthy Start screen or risk assessment as they are not currently eligible for Healthy Start services. There is a public health benefit served by screening these families. These families may benefit from the prevention and child development services offered by Healthy Start.<br><br>Newborns and their families that are referred to CWS for threatened harm may not have cases opened by CWS. Currently the child will become ineligible for Healthy Start services if three months lapse before CWS closes the case. These families may benefit from the prevention and child development services offered by Healthy Start. | 1. Healthy Start policy should be revised so that screening and assessment occurs with families with newborns with active CWS cases.<br><br>Healthy Start workers may require additional training to accurately assess these families given the potential for resistance and risk that they present.<br><br>Case information will be shared between Healthy Start and CWS.<br><br>Healthy Start will keep the case open until CWS makes a decision about disposition.<br>2. Healthy Start eligibility will be extended up to one year for any infant where there has been CWS involvement. This will allow "re-entry" or admission to Healthy Start if the CWS closes the case during the course of the infant's first year.<br><br>3. CWS policy will include referring open and active cases of infants up to age one, to Healthy Start, provided Healthy Start is not the only service provider in the case (other services would be "side by side" with Healthy Start). |

| Issue/Problem | Preliminary Program Recommendation |
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| | A separate funding contract between Healthy Start and CWS should be considered for these types of cases.<br><br>When these CWS cases are referred to Healthy Start they will: 1) need to be tracked separately in the Healthy Start data base for evaluation purposes; 2) require different weighting so that Healthy Start home visitation workers with these families have fewer cases. |
| **High Risk Families that Refuse Healthy Start Services**<br>About 15% of the families that refuse Healthy Start services at intake are families that scored high (50 or over, considered at very high risk) on the Family Stress Checklist. These families may not come to the attention of service providers again until there are problems that necessitate CWS involvement. Better communication and coordination between Healthy Start and CWS may aid in working together to ensure these high risk families receive appropriate services. | 4. There should be coordinated, validated assessment tools used by CWS, Healthy Start and Diversion programs.<br><br>5. There should be joint training between CWS and Healthy Start to promote better understanding of each other's programs.<br><br>6. Healthy Start should refer families to CWS when there are current substantial concerns such as: on-going domestic violence in the home; substance abuse in the home; or inappropriate disciplinary practices. |

| Issue/Problem | Preliminary Program Recommendation |
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| | 7. Healthy Start programs should receive additional encouragement to conduct more prenatal outreach (in FY 2003 approximately 3% of intakes were prenatal). Outreach should be directed to doctors and to pregnant women who are in high risk situations.<br><br>DOH should consider funding the outreach efforts of Healthy Start providers as a billable activity. |
| **Families Drop Out of Healthy Start Early**<br>Families drop out of Healthy Start for a wide range of reasons. About one quarter of the families who drop out of services early have scores of 50 or greater (very high risk) on the Family Stress Checklist. | 8. Healthy Start should make referrals to CWS for families that drop out of Healthy Start and that present current substantial concerns.<br><br>9. Healthy Start programs should expand efforts at creative outreach such as evening and weekend sessions and small group sessions.<br><br>10. Healthy Start programs need more training on outreach, engagement and retention strategies. |
| **Drug Exposed Infants**<br>There are limited services that specifically target drug exposed infants, under age one, and their families. These families may not | 11. Both the Family Support Workers and the Child Development Specialists in the Healthy Start program who are working with families with substance abuse |

| Issue/Problem | Preliminary Program Recommendation |
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| be identified as drug involved at the time of the infant's birth. | problems need additional training in working with substance exposed infants and in encouraging parental involvement in the infant's development that is consistent with EIS intervention.<br><br>12. Develop or adapt from other programs, additional assessment and intervention tools for working with substance abusing families and their infants.<br><br>13. All substance exposed infants should receive the highest level of developmental screening. |
| **Families Referred to CWS**<br>Typically when a Healthy Start family is referred to CWS the Healthy Start case will be closed. This creates a problem as the case with CWS may not be confirmed, or may not remain active. If CWS closes the case, then the family may not be receiving services from any provider, and are not eligible to return to Healthy Start (if the child is more than three months old). | 14. Revise Healthy Start policy so that the case is kept open through the CWS referral and investigation process. If the case is closed by CWS, Healthy Start services will continue. If the case is active and open by CWS, Healthy Start may be a service provider (either on a continuing basis, or as a returning case) as long as Healthy Start is not the only service provider.(Healthy Start services will be "side by side" with other services coordinated by CWS).<br><br>These cases should be handled under a separate service and funding contract |

| Issue/Problem | Preliminary Program Recommendation |
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| | between Healthy Start and CWS; also these cases should be distinguished in the Healthy Start data base for evaluation purposes. |
| **Young Children Placed in Foster Care**<br>When a young child is placed in foster care the child and family are not typically eligible for continued Healthy Start as this is now an active CWS case. In many cases the foster family needs additional services and supports that are not presently readily available to them. | 15. Healthy Start children moving into foster care require an effective assessment so that appropriate referrals can be made. The assessment should be completed in all domains and be done by a team such as Project Care at Kapiolani Medical Center. The assessment should be done in cooperation with CWS. If multiple services are recommended, the assessment team should convene a service planning meeting to be sure services are well coordinated. (This initial assessment should be available to all young children moving into foster care, not just those being served by Healthy Start.)<br><br>16. Revise Healthy Start eligibility so that services may be available to foster families. Healthy Start would be "side by side" with other services coordinated by CWS.<br><br>17. The DHS funded Comprehensive Services should be strengthened to include more capacity for child development |

| Issue/Problem | Preliminary Program Recommendation |
|---|---|
| | promotion.<br><br>18. Federal funding should be maximized to ensure that any available federal dollars are being drawn down for these services for foster children and families.<br><br>19. When the child is being returned to the family, a follow-up assessment should be conducted by the team, such as Project Care, to ensure that there is appropriate follow-up care for the child and family. This follow-up assessment should also be done in concert with CWS. |
| **Young Children Who Move to New Homes**<br>When a Healthy Start child is moved to a new family (for example, the primary caregiver is incarcerated and the child moves to a relative or hanai home) a Healthy Start assessment would be triggered. There is a question about whether the new family will be considered "at risk" and therefore eligible for Healthy Start services. | 20. Healthy Start children moving into a *hanai* or relative family home will necessitate a new assessment that considers a parent incarcerated, or otherwise absent as a stressor that is sufficient to qualify for Healthy Start eligibility. |
| **Screening and Assessment**<br>The referral process by self or service providers to Healthy Start is cumbersome. | 21. Revise Healthy Start policy on screening so that screening and assessment for Healthy Start is done through the family |

| Issue/Problem | Preliminary Program Recommendation |
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| The referral can be delayed or may not be made since a family cannot be directly referred to a Healthy Start home visitation unit. Instead, a referred family must go through screening by an intake worker who may not work for the same agency as the home visitor. | visitation provider agency when there is a self or professional referral (not a hospital screening and assessment). |
| **Prenatal Referrals to Healthy Start**<br>CWS does not generally refer prenatal cases to Healthy Start. Diversion also does not refer prenatal cases to Healthy Start. Anecdotal data from Healthy Start program staff suggests that a prenatal referral to Healthy Start increases retention rates. | 22. CWS policy should be to make direct referrals of prenatal cases to Healthy Start, rather than going through Diversion. Or, Diversion should be encouraged by CWS to refer prenatal cases to Healthy Start. |
| **Diversion Contract**<br>According to the contract with DHS, the Diversion contractor is required to link the family with services. The only follow-up is at three and six months, to see if the family has had an open CWS case. The contractor is not required to do any other follow-up on whether the family has continued with the referred service provider. | 23. The CWS Diversion contract should be revised to include a follow-up by the diversion service to confirm that the family is working with the referred service provider. |
| **Additional Evaluation Data Needed**<br>Evaluation data that helps the contractor (DOH) and the Healthy Start providers understand how the program is being | 24. Additional program evaluation should be conducted on the Healthy Start program that addresses questions about implementation as well as program |

| Issue/Problem | Preliminary Program Recommendation |
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| implemented and the results it is producing with various types of families is critical.<br><br>Aggregate program level data must also be available for sharing between CWS and Healthy Start so that program outcomes can be better analyzed and assessed. | outcomes.<br><br>25. Data sharing protocols should be put in place to ensure the sharing of aggregate program level data between CWS and Healthy Start for analysis and program improvements. |

**Preliminary Policy Recommendations**: these recommendations may require legislative action. These recommendations may be pursued by other groups. SCR 13 Task Force is interested in lending its support to groups advocating for these initiatives. For recommendations that are not considered by the Legislature in 2004, the Task Force may develop a legislative package for the 2005 Legislature.

| Issue/Problem | Preliminary Policy Recommendation |
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| **Families with Substance Abuse Problems**<br>Families with substance abuse problems that also have young children often cannot find treatment, or if they can find treatment they must leave their young children. | 1. Additional inpatient and outpatient substance abuse treatment programs should be made available to families with young children. |
| **Families At Very High Risk**<br>There are limited services that specifically target infants, under age one, that are drug-exposed, and their families. These families | 2. Specifically for very high risk families and those with drug exposed infants, reintroduce the "Mother Infant Support Team (MIST) Program" or a similar |

| Issue/Problem | Preliminary Policy Recommendation |
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| may not be identified at birth. | program that includes the following features:<br>✍ Multidisciplinary, including substance abuse expertise<br>✍ Contracted by DHS<br>✍ Home visitor and child development foci (more intensive services than Healthy Start)<br>✍ Workers trained with Healthy Start<br>✍ Targeted to geographically high risk communities.<br>✍ Caseloads of 12 – 15 families. |

## Next steps

The Task Force developed the following plan of next steps for ensuring that the preliminary recommendations developed by the Task Force are further discussed and, as appropriate, implemented. Further, both the Department of Human Services and the Department of Health, as evidence of their commitment to this effort, agree to jointly chair the Task Force in the future.

The Task Force agrees that it will continue its efforts over the next four years to achieve the following:

**1)** Further discuss the preliminary recommendations and develop working agreements between DOH and DHS, and any other parties, to operationalize and implement the final recommendations.

**2)** ave a general plan in place for tracking, monitoring, assessing and reporting on progress on the indicators in the goal statement above, over the next four years. Additional indicators will be added as target populations are further discussed.

**3)** Complete discussion on topics identified but not addressed by the Task Group, as outlined in Attachment. To the extent possible, continue discussions on the additional populations identified above.

**4)** Develop any necessary legislation for the 2005 Legislature to support recommendations that may be developed by the Task Force and that require legislative action.

# ATTACHMENT

## Topics That Were Identified by the Task Force but Were Not Fully Discussed

- Why are numbers of CAN increasing among young children? Need child maltreatment breakdown by types of maltreatment by age for children 0 – 5.

- How effectively are families with history of substance abuse identified in the Healthy Start screening?

- Policy makers and others will need to understand the complexity of the system in order to develop appropriate policies and make good decisions (look how much difficulty we who work in the system regularly have had sorting this out).

- There need to be agreed upon rules for eligibility in Healthy Start – they need to be easy for people to understand and access, both inside and outside Healthy Start provider system.

- Explore alternatives to voluntary Healthy Start.

- Consider whether Healthy Start eligibility can be extended beyond three months to any family that is otherwise eligible.

- Consider whether it would be advantageous to have identified "threatened harm" workers within CWS to ensure there are staff with sufficient time and focus to work on prevention cases, in light of the heavy treatment caseloads currently overloading the system.